RECORDS ACCESS

144.292 PATIENT RIGHTS.

Subdivision 1. **Scope.** Patients have the rights specified in this section regarding the treatment the patient receives and the patient's health record.

Subd. 2. **Patient access.** Upon request, a provider shall supply to a patient complete and current information possessed by that provider concerning any diagnosis, treatment, and prognosis of the patient in terms and language the patient can reasonably be expected to understand.

Subd. 3. **Additional patient rights.** A patient's right specified in this section and sections 144.293 to 144.298 are in addition to the rights specified in sections 144.651 and 144.652 and any other provision of law relating to the access of a patient to the patient's health records.

Subd. 4. **Notice of rights; information on release.** A provider shall provide to patients, in a clear and conspicuous manner, a written notice concerning practices and rights with respect to access to health records. The notice must include an explanation of:

(1) disclosures of health records that may be made without the written consent of the patient, including the type of records and to whom the records may be disclosed; and

(2) the right of the patient to have access to and obtain copies of the patient's health records and other information about the patient that is maintained by the provider. The notice requirements of this subdivision are satisfied if the notice is included with the notice and copy of the patient and resident bill of rights under section 144.652 or if it is displayed prominently in the provider's place of business. The commissioner of health shall develop the notice required in this subdivision and publish it in the State Register.

Subd. 5. **Copies of health records to patients.** Except as provided in section 144.296, upon a patient's written request, a provider, at a reasonable cost to the patient, shall promptly furnish to the patient:

(1) copies of the patient's health record, including but not limited to laboratory reports, x-rays, prescriptions, and other technical information used in assessing the patient's health conditions; or

(2) the pertinent portion of the record relating to a condition specified by the patient. With the consent of the patient, the provider may instead furnish only a summary of the record. The provider may exclude from the health record written speculations about the patient's health condition, except that all information necessary for the patient's informed consent must be provided.

Subd. 6. **Cost.** (a) When a patient requests a copy of the patient's record for purposes of reviewing current medical care, the provider must not charge a fee.

(b) When a provider or its representative makes copies of patient records upon a patient's request under this section, the provider or its representative may charge the patient or the patient's representative no more than 75 cents per page, plus $10 for time spent retrieving and copying the records, unless other law or a rule or contract provide for a lower maximum charge. This limitation does not apply to x-rays. The provider may charge a patient no more than the actual cost of reproducing x-rays, plus no more than $10 for the time spent retrieving and copying the x-rays.

(c) The respective maximum charges of 75 cents per page and $10 for time provided in this subdivision are in effect for calendar year 1992 and may be adjusted annually each calendar year

as provided in this subdivision. The permissible maximum charges shall change each year by an amount that reflects the change, as compared to the previous year, in the Consumer Price Index for all Urban Consumers, Minneapolis-St. Paul (CPI-U), published by the Department of Labor.

(d) A provider or its representative must not charge a fee to provide copies of records requested by a patient or the patient's authorized representative if the request for copies of records is for purposes of appealing a denial of Social Security disability income or Social Security disability benefits under title II or title XVI of the Social Security Act. For the purpose of further appeals, a patient may receive no more than two medical record updates without charge, but only for medical record information previously not provided. For purposes of this paragraph, a patient's authorized representative does not include units of state government engaged in the adjudication of Social Security disability claims.

Subd. 7. **Withholding health records from patient.** (a) If a provider, as defined in section 144.291, subdivision 2, paragraph (h), clause (1), reasonably determines that the information is detrimental to the physical or mental health of the patient, or is likely to cause the patient to inflict self harm, or to harm another, the provider may withhold the information from the patient and may supply the information to an appropriate third party or to another provider, as defined in section 144.291, subdivision 2, paragraph (h), clause (1). The other provider or third party may release the information to the patient.

(b) A provider, as defined in section 144.291, subdivision 2, paragraph (h), clause (3), shall release information upon written request unless, prior to the request, a provider, as defined in section 144.291, subdivision 2, paragraph (h), clause (1), has designated and described a specific basis for withholding the information as authorized by paragraph (a).

Subd. 8. **Form.** By January 1, 2008, the Department of Health must develop a form that may be used by a patient to request access to health records under this section. A form developed by the commissioner must be accepted by a provider as a legally enforceable request under this section.

History: *2007 c 147 art 10 s 3*

144.293 RELEASE OR DISCLOSURE OF HEALTH RECORDS.

Subdivision 1. **Release or disclosure of health records.** Health records can be released or disclosed as specified in subdivisions 2 to 9 and sections 144.294 and 144.295.

Subd. 2. **Patient consent to release of records.** A provider, or a person who receives health records from a provider, may not release a patient's health records to a person without:

(1) a signed and dated consent from the patient or the patient's legally authorized representative authorizing the release;

(2) specific authorization in law; or

(3) a representation from a provider that holds a signed and dated consent from the patient authorizing the release.

Subd. 3. **Release from one provider to another.** A patient's health record, including,

but not limited to, laboratory reports, x-rays, prescriptions, and other technical information used in assessing the patient's condition, or the pertinent portion of the record relating to a specific condition, or a summary of the record, shall promptly be furnished to another provider upon the written request of the patient. The written request shall specify the name of the provider to whom the health record is to be furnished. The provider who furnishes the health record or summary may retain a copy of the materials furnished. The patient shall be responsible for the reasonable costs of furnishing the information.

Subd. 4. **Duration of consent.** Except as provided in this section, a consent is valid for one year or for a lesser period specified in the consent or for a different period provided by law.

Subd. 5. **Exceptions to consent requirement.** This section does not prohibit the release of health records:

(1) for a medical emergency when the provider is unable to obtain the patient's consent due to the patient's condition or the nature of the medical emergency;

(2) to other providers within related health care entities when necessary for the current treatment of the patient; or

(3) to a health care facility licensed by this chapter, chapter 144A, or to the same types of health care facilities licensed by this chapter and chapter 144A that are licensed in another state when a patient:

(i) is returning to the health care facility and unable to provide consent; or

(ii) who resides in the health care facility, has services provided by an outside resource under Code of Federal Regulations, title 42, section 483.75(h), and is unable to provide consent.

Subd. 6. **Consent does not expire.** Notwithstanding subdivision 4, if a patient explicitly gives informed consent to the release of health records for the purposes and restrictions in clauses (1) and (2), the consent does not expire after one year for:

(1) the release of health records to a provider who is being advised or consulted with in connection with the releasing provider's current treatment of the patient;

(2) the release of health records to an accident and health insurer, health service plan corporation, health maintenance organization, or third-party administrator for purposes of payment of claims, fraud investigation, or quality of care review and studies, provided that:

(i) the use or release of the records complies with sections 72A.49 to 72A.505;

(ii) further use or release of the records in individually identifiable form to a person other than the patient without the patient's consent is prohibited; and

(iii) the recipient establishes adequate safeguards to protect the records from unauthorized disclosure, including a procedure for removal or destruction of information that identifies the patient.

Subd. 7. **Exception to consent.** Subdivision 2 does not apply to the release of health records to the commissioner of health or the Health Data Institute under chapter 62J, provided that the commissioner encrypts the patient identifier upon receipt of the data.

Subd. 8. **Record locator service.** (a) A provider or group purchaser may release patient identifying information and information about the location of the patient's health records to a record locator service without consent from the patient, unless the patient has elected to be

excluded from the service under paragraph (d). The Department of Health may not access the record locator service or receive data from the record locator service. Only a provider may have access to patient identifying information in a record locator service. Except in the case of a medical emergency, a provider participating in a health information exchange using a record locator service does not have access to patient identifying information and information about the location of the patient's health records unless the patient specifically consents to the access. A consent does not expire but may be revoked by the patient at any time by providing written notice of the revocation to the provider.

(b) A health information exchange maintaining a record locator service must maintain an audit log of providers accessing information in a record locator service that at least contains information on:

(1) the identity of the provider accessing the information;

(2) the identity of the patient whose information was accessed by the provider; and

(3) the date the information was accessed.

(c) No group purchaser may in any way require a provider to participate in a record locator service as a condition of payment or participation.

(d) A provider or an entity operating a record locator service must provide a mechanism under which patients may exclude their identifying information and information about the location of their health records from a record locator service. At a minimum, a consent form that permits a provider to access a record locator service must include a conspicuous check-box option that allows a patient to exclude all of the patient's information from the record locator service. A provider participating in a health information exchange with a record locator service who receives a patient's request to exclude all of the patient's information from the record locator service or to have a specific provider contact excluded from the record locator service is responsible for removing that information from the record locator service.

Subd. 9. **Documentation of release.** (a) In cases where a provider releases health records without patient consent as authorized by law, the release must be documented in the patient's health record. In the case of a release under section 144.294, **subdivision 2**, the documentation must include the date and circumstances under which the release was made, the person or agency to whom the release was made, and the records that were released.

(b) When a health record is released using a representation from a provider that holds a consent from the patient, the releasing provider shall document:

(1) the provider requesting the health records;

(2) the identity of the patient;

(3) the health records requested; and

(4) the date the health records were requested.

Subd. 10. **Warranties regarding consents, requests, and disclosures.** (a) When requesting health records using consent, a person warrants that the consent:

(1) contains no information known to the person to be false; and

(2) accurately states the patient's desire to have health records disclosed or that there is specific authorization in law.

(b) When requesting health records using consent, or a representation of holding a consent, a

provider warrants that the request:
(1) contains no information known to the provider to be false;
(2) accurately states the patient's desire to have health records disclosed or that there is specific authorization in law; and
(3) does not exceed any limits imposed by the patient in the consent.
(c) When disclosing health records, a person releasing health records warrants that the person:
(1) has complied with the requirements of this section regarding disclosure of health records;
(2) knows of no information related to the request that is false; and
(3) has complied with the limits set by the patient in the consent.
History: *2007 c 147 art 10 s 4*

144.294 RECORDS RELATING TO MENTAL HEALTH.
Subdivision 1. **Provider inquiry.** Upon the written request of a spouse, parent, child, or sibling of a patient being evaluated for or diagnosed with mental illness, a provider shall inquire of a patient whether the patient wishes to authorize a specific individual to receive information regarding the patient's current and proposed course of treatment. If the patient so authorizes, the provider shall communicate to the designated individual the patient's current and proposed course of treatment. Section 144.293, subdivisions 2 and 4, apply to consents given under this subdivision.
Subd. 2. **Disclosure to law enforcement agency.** Notwithstanding section 144.293, subdivisions 2 and 4, a provider must disclose health records relating to a patient's mental health to a law enforcement agency if the law enforcement agency provides the name of the patient and communicates that the:
(1) patient is currently involved in an emergency interaction with the law enforcement agency; and
(2) disclosure of the records is necessary to protect the health or safety of the patient or of another person. The scope of disclosure under this subdivision is limited to the minimum necessary for law enforcement to respond to the emergency. A law enforcement agency that obtains health records under this subdivision shall maintain a record of the requestor, the provider of the information, and the patient's name. Health records obtained by a law enforcement agency under this subdivision are private data on individuals as defined in section 13.02, subdivision 12, and must not be used by law enforcement for any other purpose.
Subd. 3. **Records release for family and caretaker; mental health care.** (a) Notwithstanding section 144.293, a provider providing mental health care and treatment may disclose health record information described in paragraph (b) about a patient to a family member of the patient or other person who requests the information if:
(1) the request for information is in writing;
(2) the family member or other person lives with, provides care for, or is directly involved in monitoring the treatment of the patient;
(3) the involvement under clause (2) is verified by the patient's mental health care provider, the patient's attending physician, or a person other than the person requesting the information, and is documented in the patient's medical record;
(4) before the disclosure, the patient is informed in writing of the request, the name of the person requesting the information, the reason for the request, and the specific information

being requested;
(5) the patient agrees to the disclosure, does not object to the disclosure, or is unable to consent or object, and the patient's decision or inability to make a decision is documented in the patient's medical record; and
(6) the disclosure is necessary to assist in the provision of care or monitoring of the patient's treatment.
(b) The information disclosed under this paragraph is limited to diagnosis, admission to or discharge from treatment, the name and dosage of the medications prescribed, side effects of the medication, consequences of failure of the patient to take the prescribed medication, and a summary of the discharge plan.
(c) If a provider reasonably determines that providing information under this subdivision would be detrimental to the physical or mental health of the patient or is likely to cause the patient to inflict self harm or to harm another, the provider must not disclose the information.
(d) This subdivision does not apply to disclosures for a medical emergency or to family members as authorized or required under subdivision 1 or section 144.293, subdivision 5, clause (1).